Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Medical Nutrition

(Formerly part of Infusion/Enteral/Parenteral)

Billing Instructions

November 2000

About this publication

This publication supersedes the Enteral portion of MAA's Infusion/Enteral/Parenteral Billing Instructions and Numbered Memorandum 00-50 MAA.

Related programs have their own billing instructions. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Home Health Services
- Nutritional Counseling
- Prescription Drug Program

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
November 2000

Where do I get other copies of billing instructions?

Check out MAA's web site
http://maa.dshs.wa.gov **-or-**

Write/Call:
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562
1-800-562-6188

Received too many billing instructions?
Too few?
Address incorrect?
Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

Table of Contents

Table of Contents (cont.)

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

Where do I call for information on becoming a DSHS provider?

Provider Enrollment Unit
(800) 562-6188, **Select Option 1** or call
(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my HCFA-1500 claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain a limitation extension?

Copy and complete the Limitation Extension Request Form (included in this billing instruction) and fax to:

(360) 586-2262

Who do I contact if I have questions on…

Payments, denials, general questions regarding claims processing, Healthy Options?

Provider Relations Unit (PRU)
1-800-562-6188

Private insurance or third party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136

Access Issues, Broker Transportation, Client Complaints, Healthy Options Enrollment, Disenrollment, Exemptions?

Medical Assistance Customer Service Center (MACSC) (Clients Only)
1-800-562-3022

Eligibility for Children's Medical, Healthy Options and Basic Health Plus?

Medical Eligibility Determination Services (MEDS)
1-800-204-6429

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Acute - A medical condition of severe intensity with sudden onset.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

By Report (BR) - When a service, supply, or piece of equipment is new (its use is not yet considered standard), or it is a variation on a standard practice, or it is rarely provided, or it has no maximum allowance established, it may be designated ***By Report***. Any service or item classified as ***By Report*** is evaluated for its medical appropriateness and maximum allowance on a case-by-case basis.

Client - An applicant for, or recipient of, DSHS medical care programs. (WAC 388-500-0005)

Client Support, Division of (DCS) – The division within MAA responsible for:

- Client enrollments, exemptions and disenrollments in managed care plans;
- Coordination of Medicare and private insurance benefits;
- Transportation and interpreter services;
- Operation of a customer service hot-line;
- Administration of a centralized children's eligibility section and Children's Health Insurance Program (CHIP) eligibility policy, marketing and outreach.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the MAA program.

Deductible - An initial, specified, amount that is the responsibility of the client.

(a) Part A of Medicare - inpatient hospital deductible' means an initial amount of the medical care cost in each benefit period which Medicare does not pay.

(b) Part B of Medicare - physician deductible' means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay. (WAC 388-500-0005)

Department - The state Department of Social and Health Services [DSHS]. (WAC 388-500-0005)

Durable Medical Equipment (DME) – Equipment that:

(a) Can withstand repeated use;
(b) Is primarily and customarily used to serve a medical purpose;
(c) Generally is not useful to a person in the absence of illness or injury; and
(d) Is appropriate for use in the client's place of residence.

Duration of Therapy - The estimated span of time that therapy will be needed for a medical problem.

Emergency Services - Services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Episode - A continuous period of treatment regardless of the number of therapies involved.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.
(WAC 388-551-2010)

Internal Control Number (ICN) - A 17-digit number that appears on your *Remittance and Status Report* by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

Limitation Extension – Prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in MAA's billing instructions.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
(WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Care Provider – Physician, Physician Assistant (PA), Advanced Registered Nurse Practitioner (ARNP), and Certified Dietitian.

Medical Consultant - A physician employed by the department. (WAC 388-500-0005)

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medical Nutrition Therapy – The use of medical formulas, either alone or in combination with traditional food, when a client is unable to consume enough traditional food to meet their nutritional requirements. Medical nutritionals can be given orally or via feeding tubes.

Medical Nutritionals – The medical products used when providing Medical Nutrition Therapy.

Medicare - The federal government health insurance program, for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Parenteral Nutrition - A type of therapy considered reasonable and necessary for a client with severe pathology of the alimentary tract which consists of the administration of nutrients (i.e., glucose, amino acids, fats, vitamins and minerals) intravenously either by central or by peripheral vein. Parenteral nutrition is appropriate only when oral or enteral feeding is inadequate or contraindicated.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Prior Authorization – Approval required from MAA prior to providing services, for certain services, items, or supplies based on medical necessity.

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Purchase Only (P.O.) - A type of purchase used only when either the cost of the item makes purchasing it more cost effective than renting it, or it is a personal item, such as a ventilator mask, appropriate only for a single user.

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Rental - A monthly or daily rental fee paid for equipment.

Revised Code of Washington (RCW) - Washington state laws.

Skilled Nursing Facility (SNF) - An institution or part of an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care;
- Rehabilitation services for injured, disabled or sick clients;
- Health-related care and services to individuals who, because of their mental or physical conditions, require care which can only be provided through institutional facilities

and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005

Total Medical Nutrition – Medical nutritionals used to meet 100% of a client's nutritional requirement.

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

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About the Program

What is the purpose of MAA's Medical Nutrition Program?

The purpose of MAA's Medical Nutrition Program is to reimburse for medically necessary nutritionals and related supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness.

> **Note:** All medical nutrition must be medically necessary and the medical necessity for the product being supplied must be evident in the diagnostic code on the claim. If the diagnostic code on the claim does not support the medical need for medical nutrition, MAA may recoup the payment.

Who is eligible to bill for medical nutrition?

Providers that have been assigned MAA provider numbers for the following provider types:

- Durable Medical Equipment; and/or
- Pharmacy.

See *Important Contacts* section for information on applying for a provider number.

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Client Eligibility

Who is eligible?

Clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are eligible for medical nutrition and supplies:

MAID Identifier	Medical Program
CNP	Categorically Needy Program
CNP - Children's Health	Categorically Needy Program – Children's Health
CNP - CHIP	Categorically Needy Program – Children's Health Insurance Program
GA-U No Out of State Care	General Assistance – Unemployable
LCP - MNP	Limited Casualty Program-Medically Needy Program
QMB-Medicare Only	Qualified Medicare Beneficiary – Medicare Only **See page I.5 for details of coverage.**

Are clients enrolled in a Healthy Option's managed care plan eligible for medical nutrition?

Yes! Clients who are enrolled in a Healthy Option's managed care plan are eligible for medical nutrition. These clients will have an HMO identifier in the HMO column on their MAID cards. Medical nutritionals and supplies must be requested through the client's Primary Care Provider (PCP). See the 1-800 telephone number listed on the client's MAID card.

☞ **Note:** If you treat a Healthy Options client and you are not the client's Primary Care Provider (PCP), or the client was not referred to you by the PCP, you may not receive payment. You will need to contact the PCP to get a referral. You may also need to get authorization from the plan for the service that you are providing, especially if you are not contracted as a provider with that plan. Call the Managed Care Plan to discuss payment before you provide services.

Newborns of Healthy Options clients are the responsibility of the mother's plan for the first 60 days of life. If the mother changes plans, the baby follows the mother.

Primary Care Case Manager/Management:

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's MAID card for the PCCM.

Coverage

> **Note: All medical nutrition must be medically necessary and the medical necessity for the product being supplied must be evident in the diagnosis code on the claim. If the diagnosis code does not evidence the medical need for medical nutrition, MAA may recoup the payment.**

MAA's previous policy of medical nutritional being allowed only when 50% of the client's caloric need is no longer applicable. See Modifier section.

- All products and supplies must be medically necessary and meet the guidelines in this billing instruction.
- Unless otherwise approved through the limitation extension process, MAA covers only the products listed in this billing instruction.
- For non-formula products covered by MAA, the product name will include the type of product (e.g., bars).
- Only medical nutritionals with an individually assigned procedure code listed in the fee schedule will be considered for coverage by MAA.
- The client's Department of Health's Supplemental Nutrition Program for Women, Infants, and Children (WIC) allotments must be depleted (when applicable) prior to billing MAA for any medical nutritionals.
- MAA does not pay for:
  - ✓ Medical nutritionals when nutritional needs can be met using traditional foods; and/or
  - ✓ Baby food and other regular grocery products that can be pulverized and used as medical nutritionals.
- A certified dietitian must evaluate all clients 17 years of age and younger within 30 days of initiation of medical nutritionals, and periodically (at the discretion of the certified dietitian) while on medical nutritionals. A copy of this evaluation must be retained in the client's file.

  With dates of service on and after January 1, 2001, the above mentioned certified dietitians must have an MAA-assigned provider number.

Nutritional Counseling

MAA pays for nutritional counseling services provided by a certified dietitian, for clients 20 years of age and younger, when the client is referred by a Healthy Kids/EPSDT provider.

Refer to MAA's Nutritional Counseling Billing Instructions, dated October 2000, for further information (see *Important Contacts* section for information on where to get copies of billing instructions).

Effective for dates of service on and after January 1, 2001, providers billing for medical nutritionals for clients 17 years of age and younger must put the provider number of the certified dietitian in field 17A on the HCFA-1500 claim form.

WIC

(Supplemental Nutrition Program for Women, Infants, and Children)

Before billing MAA for medical nutritionals **(oral and tube fed)** for clients 4 years of age and younger, you must have one of the following:

1. WIC denial and an "F" indicator on the claim indicating that WIC is not being used; or
2. Documentation that the client's WIC allotment has been depleted.

Anytime WIC is not being used for clients 4 years old and younger, you must use an "F" indicator in field 19 on the HCFA-1500 claim form.

Clients in a Nursing Facility

- Medical nutritionals (and related supplies) are not included in the nursing facility per diem when the:

  - ✓ Medical nutritionals are used to meet 100% of the client's nutritional demands;* and
  - ✓ Client's medical circumstance(s) qualify for the use of medical nutritionals.

  * When billing for client's in nursing homes that qualify for reimbursement of medical nutritionals, providers must add the statement *"100 % nutrition - not included in NH"* in field 19 of the HCFA-1500 claim form or in the *Remarks* field on electronic claims.

Clients in a State-Owned Facility

All medical nutrition products/supplies/equipment for MAA clients in state-owned facilities (state school, developmental disabilities (DD) facilities, mental health facilities, Western and Eastern state hospitals) are purchased by the facilities through a contract with manufacturers. Services for these clients are not reimbursed separately by MAA.

Clients who have elected MAA's hospice benefit

MAA pays for medical nutritionals, separate from the hospice per diem, only when the reason for the medical nutritionals is completely unrelated to the terminal diagnosis that qualifies the client for the hospice benefit. You must enter a "K" indicator in field 19 on the HCFA-1500 claim form to identify that the medical nutritionals are **unrelated to the terminal diagnosis.**

Clients who are receiving Medicare Part B Benefits

MAA pays for medical nutritionals for clients on Medicare Part B only when the clients are not tube-fed and when the client meets the criteria in these billing instructions. When billing for these clients, it is not necessary to bill with a Medicare denial. However, you must put the statement *"Not tube fed - Medicare does not cover"* in field 19 of the HCFA-1500 claim form or in the *Remarks* field on electronic claims.

Medical Nutritionals Used In Combination with Parenteral Nutrition

Can I get paid for both Medical Nutritionals and Parenteral Nutrition?

MAA pays for up to 3 months of medical nutritionals/supplies and parenteral nutrition/supplies while a client is being transitioned from parenteral to medical nutritionals.

If the transition period exceeds 3 months, you must enter an "L" indicator in field 19 on the HCFA-1500 claim form to indicate that while the expected transition time has been exceeded, the client is still transitioning to medical nutritionals.

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Modifiers

Effective with dates of service on and after October 1, 2003, providers must use the procedure codes listed in the product list along with a modifier, if applicable, for all medical nutritionals.

Modifier 'BO'

What does the modifier signify?

Modifier 'BO' is to be used for medically necessary, orally administered nutrition, not nutrition administered by external tube. This is the only modifier accepted by MAA for medical nutritionals.

All oral nutritionals must have documented justification for medical necessity in the client's file and made available for review by MAA. Claims for reimbursement of oral nutritionals must be billed with the ICD-9-CM diagnosis code that indicates a functional impairment of an organ or process.

Note…

Medicare Part B only covers nutritional products for clients who are tube-fed. Nutritional products being appropriately billed with a 'BO' modifier will not require a Medicare denial and can be billed directly to MAA.

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Product List

Effective with dates of service on and after October 1, 2003, providers must use the applicable HCPCS codes for all medical nutritional claims. **Please note: Modifier "BO" must be used when the product is being administered orally.**

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Units must be rounded to the nearest whole number.				
Advera	0000B	B4154	100 cal	$1.60
Additions	0412B	B4155	100 cal	$0.89
Alimentum	0001B	B4153	100 cal	$2.97
AlitraQ	0002B	B4154	100 cal	$1.60
Amino-Aid	0003B	B4154	100 cal	$1.60
Beneprotein (see Resource Beneprotein)				
Boost (with or without fiber)	0004B	B4155	100 cal	$0.89
Boost Breeze	0400B	B4155	100 cal	$0.89
Boost HP	0005B	B4150	100 cal	$0.92
Boost Plus	0006B	B4152	100 cal	$0.62
Calcilco XD Pwd	0388B	B4154	100 cal	$1.60
Carnation Alsoy	0008B	B4150	100 cal	$0.92
Carnation Follow-up	0009B	B4150	100 cal	$0.92
Carnation Good Start	0010B	B4150	100 cal	$0.92
Casec	0011B	B4155	100 cal	$0.89
Choice DM	0012B	B4154	100 cal	$1.60
Choice DM Bar **(EPA required; use # 870000868. See page G.1.)**	0013B	B9998	100 cal	$0.72
Compleat Modified	0014B	B4151	100 cal	$0.94
Compleat Pediatric	0015B	B4151	100 cal	$0.94
Comply	0016B	B4152	100 cal	$0.62
Criticare HN	0017B	B4153	100 cal	$2.97
Crucial	0019B	B4153	100 cal	$2.97
Cyclinex 1	0021B	B4153	100 cal	$2.97
Cyclinex 2	0023B	B4153	100 cal	$2.97
Deliver 2.0	0025B	B4152	100 cal	$0.62

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Units must be rounded to the nearest whole number.				
Diabetisource	0027B	B4154	100 cal	$1.60
Diabetisource AC	0411B	B4154	100 cal	$1.60
Duocal	0414B	B4155	100 cal	$0.89
Elecare	0028B	B4153	100 cal	$2.97
Enfacare	0029B	B4150	100 cal	$0.92
Enfamil	0365B	B4150	100 cal	$0.92
Enfamil 22	0030B	B4150	100 cal	$0.92
Enfamil AR	0031B	B4150	100 cal	$0.92
Enfamil LactoFree	0032B	B4150	100 cal	$0.92
Enfamil Next Step	0033B	B4150	100 cal	$0.92
Enlive	0034B	B4150	100 cal	$0.92
Ensure (with or without fiber)	0039B	B4150	100 cal	$0.92
Ensure Bar **(EPA required; use # 870000868. See page G.1.)**	0035B	B9998	100 cal	$0.72
Ensure High Protein	0036B	B4150	100 cal	$0.92
Ensure Plus	0037B	B4152	100 cal	$0.62
Ensure Plus HN	0038B	B4152	100 cal	$0.62
FAA (Free Amino Acid Diet)	0397B	B4153	100 cal	$2.97
FiberSource	0040B	B4150	100 cal	$0.92
FiberSource HN	0041B	B4150	100 cal	$0.92
GA 1 and 2	0042B	B4153	100 cal	$2.97
Generic/Store Brand Formula ***Note:*** *Providers may bill for Generic or Store Brand products only when the content of the product is the same as Ensure, Boost, or NuBasics.*	0399B	B4150	100 cal	$0.92
Glucerna	0043B	B4154	100 cal	$1.60
Glucerna Bar **(EPA required; use # 870000868. See page G.1.)**	0044B	B9998	100 cal	$0.72
Glucerna Shake	0045B	B4154	100 cal	$1.60
Glutarex 1	0046B	B4153	100 cal	$2.97
Glutarex 2	0047B	B4153	100 cal	$2.97
Glutasorb	0385B	B4153	100 cal	$2.97

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Units must be rounded to the nearest whole number.				
Glytrol	0048B	B4150	100 cal	$0.92
HCY 1 and 2	0049B	B4154	100 cal	$1.60
Hepatic-Aid	0050B	B4154	100 cal	$1.60
Hominex 1	0051B	B4153	100 cal	$2.97
Hominex 2	0052B	B4153	100 cal	$2.97
Immun-Aid	0053B	B4154	100 cal	$1.60
Immunocal	0389B	B4155	100 cal	$0.89
Impact 1.5	0054B	B4154	100 cal	$1.60
Impact (with or without fiber)	0055B	B4154	100 cal	$1.60
Impact Glutamine	0417B	B4153	100 cal	$2.97
Impact Recover	0415B	B4154	100 cal	$1.60
Isocal	0056B	B4150	100 cal	$0.92
Isocal HN	0057B	B4150	100 cal	$0.92
Isocal HN Plus	0390B	B4150	100 cal	$0.92
Isomil	0059B	B4150	100 cal	$0.92
Isomil DF	0061B	B4150	100 cal	$0.92
Isosource 1.5	0064B	B4152	100 cal	$0.62
Isosource	0063B	B4150	100 cal	$0.92
Isosource HN	0065B	B4150	100 cal	$0.92
Isosource VHN	0066B	B4154	100 cal	$1.60
Isotein HN	0067B	B4153	100 cal	$2.97
Jevity	0068B	B4150	100 cal	$0.92
Jevity Plus	0069B	B4150	100 cal	$0.92
Juven (powder)	N/A	B4155	100 cal	$0.89
KetoCal	0410B	B4151	100 cal	$0.94
Ketonex 1	0071B	B4153	100 cal	$2.97
Ketonex 2	0073B	B4153	100 cal	$2.97
Kindercal	0075B	B4150	100 cal	$0.92
Kindercal TF w/Fiber	0391B	B4150	100 cal	$0.92
Lipisorb Liquid	0077B	B4154	100 cal	$1.60
L-Emental	0380B	B4153	100 cal	$2.97
L-Emental Hepatic	0381B	B4154	100 cal	$1.60
Lofenalac	0079B	B4154	100 cal	$1.60

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Units must be rounded to the nearest whole number.				
LYS 1 and 2	0081B	B4154	100 cal	$1.60
Magnacal Renal	0083B	B4154	100 cal	$1.60
MCT Oil	0085B	B4155	100 cal	$0.89
Microlipids	0087B	B4155	100 cal	$0.89
Modulen IBD	0395B	B4154	100 cal	$1.60
MSUD	0089B	B4154	100 cal	$1.60
MSUD 2	0091B	B4154	100 cal	$1.60
Neocate	0093B	B4153	100 cal	$2.97
Neocate One Plus	0095B	B4153	100 cal	$2.97
NeoSure	0097B	B4150	100 cal	$0.92
Nepro	0100B	B4154	100 cal	$1.60
Novasource 2.0	0406B	B4152	100 cal	$0.62
Novasource Renal	0101B	B4154	100 cal	$1.60
Novasource Pulmonary	0102B	B4152	100 cal	$0.62
NuBasics (with or without fiber)	0108B	B4150	100 cal	$0.92
NuBasics 2.0	0103B	B4152	100 cal	$0.62
NuBasics Bar **(EPA required; use # 870000868. See page G.1.)**	0104B	B9998	100 cal	$0.72
NuBasics Fruit Beverage	0105B	B4150	100 cal	$0.92
NuBasics Plus	0106B	B4152	100 cal	$0.62
NuBasics VHP	0107B	B4150	100 cal	$0.92
Nutramigen	0109B	B4150	100 cal	$0.92
Nutren 1.0 (with or without fiber)	0110B	B4150	100 cal	$0.92
Nutren 1.5	0111B	B4152	100 cal	$0.62
Nutren 2.0	0113B	B4152	100 cal	$0.62
Nutren Junior (with or without) fiber	0114B	B4150	100 cal	$0.92
Nutrihep	0115B	B4154	100 cal	$1.60
Nutrirenal	0370B	B4154	100 cal	$1.60
Nutrivent	0116B	B4154	100 cal	$1.60
Optimental	0392B	B4153	100 cal	$2.97
OS 1 and 2	0117B	B4154	100 cal	$1.60
Osmolite	0118B	B4150	100 cal	$0.92
Osmolite HN	0119B	B4150	100 cal	$0.92
Osmolite HN Plus	0120B	B4150	100 cal	$0.92

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Units must be rounded to the nearest whole number.				
Pediasure (with or without fiber)	0121B	B4150	100 cal	$0.92
Ped Peptinex DT (with or without fiber)	N/A	B4153	100 cal	$2.97
Peptamen	0122B	B4154	100 cal	$1.60
Peptamen 1.5	0123B	B4153	100 cal	$2.97
Peptamen with Prebio 1	0396B	B4153	100 cal	$2.97
Peptamen Junior	0124B	B4153	100 cal	$2.97
Peptamen VHP	0125B	B4154	100 cal	$1.60
Peptinex DT	0409B	B4153	100 cal	$2.97
Perative	0126B	B4154	100 cal	$1.60
PFD2	0127B	B4155	100 cal	$0.89
Phenex 1	0128B	B4153	100 cal	$2.97
Phenex 2	0129B	B4153	100 cal	$2.97
PhenylAde	0130B	B4155	100 cal	$0.89
PhenylAde MTE	0131B	B4155	100 cal	$0.89
Phenyl-Free	0132B	B4154	100 cal	$1.60
Phenyl-Free 2	0133B	B4154	100 cal	$1.60
Phenyl-Free HP2	0134B	B4154	100 cal	$1.60
Polycose Liquid	0135B	B4155	100 cal	$0.89
Polycose Powder	0136B	B4155	100 cal	$0.89
Portagen	0137B	B4150	100 cal	$0.92
Pregestimil	0138B	B4154	100 cal	$1.60
Probalance	0139B	B4150	100 cal	$0.92
Pro-Cel	0401B	B4155	100 cal	$0.89
Product 3200AB	0140B	B4154	100 cal	$1.60
Product 3232	0141B	B4154	100 cal	$1.60
Product 80056	0142B	B4155	100 cal	$0.89
Promod	0143B	B4155	100 cal	$0.89
Promote (with or without fiber)	0145B	B4150	100 cal	$0.92
Pro-Peptide	0382B	B4154	100 cal	$1.60
Pro-Peptide VHN	0383B	B4154	100 cal	$1.60
Pro-Peptide for Kids	0384B	B4154	100 cal	$1.60
ProPhree	0147B	B4155	100 cal	$0.89
Propimex 1	0149B	B4153	100 cal	$2.97

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Units must be rounded to the nearest whole number.				
Propimex 2	0159B	B4153	100 cal	$2.97
ProSobee	0160B	B4151	100 cal	$0.94
ProSure	0413B	B4155	100 cal	$0.89
Protein Eight Bar **(EPA required; use # 870000868. See page G.1.)**	0387B	B9998	100 cal	$0.72
ProViMin	0164B	B4155	100 cal	$0.89
Pulmocare	0167B	B4154	100 cal	$1.60
RCF	0168B	B4155	100 cal	$0.89
Re/Neph	0393B	B4154	100 cal	$1.60
Reabilan	0169B	B4153	100 cal	$2.97
Reabilan HN	0170B	B4153	100 cal	$2.97
Regain Bar **(EPA required; use # 870000868. See page G.1.)**	0177B	B9998	100 cal	$0.72
Renal Cal	0178B	B4154	100 cal	$1.60
Replete (with or without fiber)	0179B	B4154	100 cal	$1.60
Resource	0180B	B4150	100 cal	$0.92
Resource Arginaid	0403B	B4155	100 cal	$0.89
Resource Bar **(EPA required; use # 870000868. See page G.1.)**	0181B	B9998	100 cal	$0.72
Resource Benecalorie	0419B	B4154	100 cal	$1.60
Resource Beneprotein	0405B	B4155	100 cal	$0.89
Resource Diabetic	0182B	B4150	100 cal	$0.92
Resource Diabetishield	0416B	B4154	100 cal	$1.60
Resource Fruit Beverage	0183B	B4150	100 cal	$0.92
Resource GlutaSolve	0407B	B4155	100 cal	$0.89
Resource Just for Kids	0184B	B4150	100 cal	$0.92
Resource Plus	0188B	B4152	100 cal	$0.62
Resource ThickenUp	0404B	B4100	1 pwd oz	$0.56
Respalor	0189B	B4152	100 cal	$0.62
SandoSource Peptide	0190B	B4154	100 cal	$1.60
Similac	0194B	B4150	100 cal	$0.92
Similac PM 60/40	0195B	B4154	100 cal	$1.60
SimplyThick **(PA Required)**	N/A	B9998	1 oz	**Submit Invoice**

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Units must be rounded to the nearest whole number.				
Suplena	0198B	B4154	100 cal	$1.60
Thick & Easy	0199B	B4100	1 pwd oz	$0.56
Thick-It	0200B	B4100	1 pwd oz	$0.56
Tolerex	0203B	B4156	100 cal	$3.55
TraumaCal	0204B	B4154	100 cal	$1.60
TwoCal HN	0386B	B4152	100 cal	$0.62
Tyrex 2	0205B	B4153	100 cal	$2.97
Tyros 2	0209B	B4154	100 cal	$1.60
UCD 1 and 2	0210B	B4154	100 cal	$1.60
Ultracal	0371B	B4150	100 cal	$0.92
Ultracal HN Plus	0394B	B4150	100 cal	$0.92
Upcal D	0402B	B4155	100 cal	$0.89
Valex 1	0217B	B4153	100 cal	$2.97
Valex 2	0218B	B4153	100 cal	$2.97
VHC 2.25	0418B	B4152	100 cal	$0.62
Vital HN	0219B	B4153	100 cal	$2.97
Vivonex Pediatric	0376B	B4153	100 cal	$2.97
Vivonex Plus	0377B	B4154	100 cal	$1.60
Vivonex TEN	0220B	B4154	100 cal	$1.60

Fiber/Hydration Products

Fiber and hydration products are covered on a limited basis through MAA's Prescription Drug Program.

How are products added to the Medical Nutritional product list?

Suppliers who want to have additional products on this list must submit the following to MAA:

- Products profile;
- Product profile of any similar products already covered by MAA;
- Category recommendation;
- Average wholesale price (AWP); and
- Certification that Medicare has approved the product.

Send your requests for consideration to:
Medical Assistance Administration
ATTN: Medical Nutrition
P.O. Box 45506
Olympia, WA 98504-5506

Prior Authorization

What is prior authorization?

Prior authorization is MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization and limitation extensions are forms of prior authorization.**

Is prior authorization required for medical nutrition?

Yes! MAA requires providers to obtain prior authorization for the following:

- HCPCS code B9998 for miscellaneous medical nutrition;
- HCPCS code B9998 for Low Profile Gastronomy Replacement Kit requires EPA #870000742 to be entered in field 19 on the HCFA-1500 claim form;
- HCPCS code B9998 for nutritional bars requires EPA #870000868 to be entered in field 19 on the HCFA-1500 claim form **for clients with fluid restrictive diets only;** and
- HCPCS code E1399 for repair parts for client-owned equipment requires EPA #870000743 to be entered in field 19 on the HCFA-1500 claim form with an invoice attached.

What is expedited prior authorization?

The expedited prior authorization (EPA) process is designed to eliminate the need for written and telephonic requests for prior authorization for selected HCPCS codes. MAA allows payment during a continuous 12-month period for this process.

To bill MAA for medical nutritionals that meet the EPA criteria on the following pages, the vendor must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000.** The last 3 digits document the product description and conditions that make up the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the **field 19** or in the ***Authorization*** or ***Comments*** field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are only billing one EPA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Example: The 9-digit EPA number for Low Profile Gastrostomy Replacement Kit for a client that meets all of the EPA criteria would be **870000742** (870000 = first 6 digits, 742 = product and documented medical condition).

Vendors are reminded that EPA numbers are only for those products listed in the fee schedule as requiring EPA numbers. EPA numbers are not valid for:

- Other medical nutritionals requiring prior authorization through the Medical Nutrition program;
- Products for which the documented medical condition does not meet all of the specified criteria; or
- Over-limitation requests.

The written/fax request for prior authorization process must be used when a situation does not meet the criteria for a selected HCPCS code. Providers must submit the request in writing and fax it to MAA at:

Division of Medical Management
Program Management and Authorization Section
Attn: Medical Nutrition Program Manager
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-1471

Expedited Prior Authorization Guidelines:

A. Medical Justification (criteria) - All medical justification must come from the client's prescribing physician with an appropriately completed prescription. MAA does not accept information obtained from the client or from someone on behalf of the client (e.g. family).

B. Documentation - The billing provider **must keep** documentation of the criteria in the client's file. Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA. Keep documentation on file for six (6) years. [Refer to WAC 388-502-0020]

☞ **Note:** MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100.

What is a limitation extension?

A limitation extension is when MAA allows additional units of service for a client when the provider can verify that the additional units of service are medically necessary. Limitation extensions require authorization.

☞ **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

When should I request a limitation extension for medical nutrition?

Under the Medical Nutrition Program, a limitation extension must be requested when it is medically necessary to provide more units of supplies than allowed in MAA's billing instructions.

How do I request a limitation extension?

In cases where the provider feels that additional services are still medically necessary for the client, the provider must request MAA-approval in writing.

The written requests must state the following:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date dispensed;
5. Copy of the oral enteral nutrition form;
6. The primary diagnosis code and HCPCS code; and
7. Client-specific clinical justification for additional services.

For medical nutritionals, submit the above information to MAA (see Important Contacts). A sample Medical Nutrition Limitation Extension Request form is on page G.5 for your convenience.

For additional units of supplies, send or fax medical justification to MAA.

Where do I send my limitation extension request?

Send or fax your request and medical justification to:

Division of Medical Management
Medical Programs Management Unit- Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-1471

☞ **Note:** All limitation extensions are subject to the client's eligibility. Not all eligibility groups receive all services. See *Client Eligibility Section*.

Medical Nutritionals Limitation Extension Request

Name, Company, Title of Requestor			
Phone Number		Fax Number	
Provider number		Patient PIC number	
Name Phone Number of Nutritionist			

Nutritional evaluation included ☐ yes ☐ No Tube Fed ☐ Yes ☐ No

Weight for this client _____ Kgs

Caloric Requirement (for this client) _____

Normal Calories per day required for someone of this age _____ Breast Fed ☐ Yes ☐ No

Diagnosis or Reason for requested formula

WIC denial enclosed or amount received from WIC _____

Type of Formula _____

Amount Required _____

Concentration used (i.e. 8oz can/1lb powder) _____

Medical Assistance Use Only

Total Cal mo		WIC Cal mo	
Remainder		Date span	
Auth Number		Procedure Code	
Units or Dollar amount			

Special Instructions

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Fee Schedule

Equipment Rental/Purchase Policy

- The following are included in MAA's reimbursement for equipment rentals or purchases:

  ✓ Instructions to the client and/or caregiver on the safe and proper use of equipment provided;
  ✓ Full service warranty;
  ✓ Delivery and pick-up; and
  ✓ Fitting and adjustments.

- If death, ineligibility, or other change in circumstances occur during the rental period, MAA will terminate reimbursement at that time.

- Providers may not bill for a rental and a purchase of any item simultaneously.

- MAA will not reimburse providers for equipment that was supplied to them **at no cost** through suppliers/manufacturers.

- All rent-to-purchase equipment must be new at the beginning of the rental period.

- MAA reimburses for medical nutrition related supplies for client's residing in nursing facilities **only:**

  ✓ When they are used to administer 100% of the client's nutritional requirements; and
  ✓ When the client's medical circumstances meet MAA's requirements for medical nutrition.

  ☞ **Note:** Covered items that are not part of the nursing home per diem may be billed separately to MAA.

- MAA reimburses for medical nutrition related supplies for client's receiving Medicare Part B **only:**

  ✓ When they are used to administer medical nutritionals to non tube-fed clients; and
  ✓ When the client's medical circumstances meet MAA's requirements for medical nutrition.

Enteral Supply Kits

- **Do not bill more than one supply kit code per day.**
- **Enteral supply kits include all the necessary supplies for the enteral patient using the syringe, gravity or pump method of nutrient administration.**
- **Bill only for the actual number of kits used, not to exceed a one-month supply.**

Procedure Code	Description	Maximum Allowable Fee	Rental	Purchase	Maximum Number of Units	Part of NH per diem
B4034	Enteral Feeding Supply Kit; Syringe (Bolus only)	$5.60	N	Y	1 per client, per day	N
B4035	Enteral Feeding Supply Kit; Pump Fed, per day.	$10.67	N	Y	Not to exceed 31 bags per month	N
B4036	Enteral Feeding Supply Kit; Gravity Fed	$7.31	N	Y	Not to exceed 31 bags per month	N

Enteral Tubing

- **You may bill only one type of enteral tube per client, per day.**
- **The total number of allowed tubes includes any tubes provided as part of the replacement kit.**

Procedure Code	Description	Maximum Allowable Fee	Rental	Purchase	Maximum Number of Units	Part of NH per diem
B4081	Nasogastric tubing with stylet (each)	$19.78	N	Y	3 per client, per month	N
B4082	Nasogastric tubing without stylet (each)	$14.73	N	Y	3 per client, per month	N
B4083	Stomach tube – Levine type (each)	$2.25	N	Y	1 per client, per month	N
B9998	Low Profile Gastrostomy Replacement Kit (e.g., Bard, MIC Key Button, Hide-a-port, Stomate). **EPA #: 870000742**	$106.87	N	Y	2 per client, every 5 months	N
B4086	Gastrostomy/jejunostomy tube, any material, any type (standard or low profile), (each)	$32.66	N	Y	5 per client, per month	N

Enteral Repairs

Procedure Codes	Description	Maximum Allowable Fee	Rental	Purchase	Maximum Number of Units	Part of NH per diem
E1399	Repair Parts for Enteral Equipment. Only those client-owned pumps less than five (5) years old, and no longer on warranty will be allowed replacement parts. **EPA #: 870000743 (Invoice required.)**	85%	N/A	N/A		N
E1340	Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.	$17.43	N/A	N/A		N

Pumps and Poles

- **May bill for only one type of enteral pump code per month.**
- **Enteral poles are considered purchased after 12 months' rental.**
- **Enteral pumps are considered purchased after 15 months' rental.**
- **Pumps must be new equipment at beginning of rental period.**

Procedure Code	Description	Maximum Allowable Fee	Rental	Purchase	Maximum Number of Units	Part of NH per diem
E0776-NU	IV pole. Purchase. Modifier required.	$93.30	N	Y	1 per client, per lifetime	Y
E0776-RR	IV pole. Rental. Modifier required.	$9.33	Per month	N	1 per month; not to exceed 12 months	Y
B9998	Case for ambulatory feeding pump. Included in pump purchase. **EPA #: 870000744.**	$100.58	N	Y	1 every 5 years	N
B9002-RR	Enteral nutrition infusion pump with alarm.	$108.66	Per month	N	1 per month; not to exceed 15 months	N

Miscellaneous						
• **MAA review is required prior to billing this code.**						
Procedure Code	**Description**	**Maximum Allowable Fee**	**Rental**	**Purchase**	**Maximum Number of Units**	**NH per diem**
B9998	NOC for enteral supplies (other medical nutrition supplies not listed).	To be determined by MAA				

Miscellaneous Procedure Code

In order to be reimbursed for miscellaneous medical nutrition procedure code B9998, all the information in the attached form must be submitted to MAA prior to submitting your claim to MAA. A sample form is attached for your convenience (see page H.5).

Do not submit claims using procedure code B9998 until you have received an authorization number from MAA indicating that your bill has been reviewed.

Include the following supporting documentation with your fax:

- Agency name and provider number;
- Client PIC;
- Date of service;
- Name of piece of equipment;
- Invoice;
- Prescription;
- Explanation of client-specific, medical necessity; and
- Name of primary piece of equipment and whether the equipment is rented or owned.

You may make copies of the attached form and mail/fax it to:

Medical Assistance Administration
Medical Nutrition Program
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

Justification for use of B9998 Miscellaneous Medical Nutrition Procedure Code
★Fax this form to obtain authorization prior to submitting your claim
Attn: Medical Nutrition Program **Fax: 360 586-1471** ***Also fax: Your Invoice Prescription***

Agency Name: _____ Agency Provider #: _____
Client Name: _____ Client PIC: _____
Client Diagnosis: _____

Date of Service: _____ Name of the Equipment: _____
Medical Necessity: _____
Units Requested _____

Date of Service: _____ Name of the Equipment: _____
Medical Necessity: _____
Units Requested _____

Date of Service: _____ Name of the Equipment: _____
Medical Necessity: _____
Units Requested _____

Date of Service: _____ Name of the Equipment: _____
Medical Necessity: _____
Units Requested _____

For MAA USE ONLY		
Decision: ☐ Approved ☐ Denied Not Medically Necessary ☐ Alternate Code suggested _____,		
Description _____, Payment per Unit _____ , Total Payment _____		
Logged Date:		Need to establish code: ☐ Yes ☐ No

General Billing

Do not bill medical nutritionals under MAA's Prescription Drug Program through Point of Sale

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

Note:	If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

How do I bill for services provided to PCCM clients?

When billing for services provided to Primary Care Case Manager (PCCM) clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for clients eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance, **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims (see page I.1).

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do no submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

NOTE:

- ✓ **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their MAID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only Medicaid **and not Medicare** cover the service and the service is covered under the CNP or MNP program, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare** does not cover the service,
MAA will not reimburse the service.

What must I keep in a client's file? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome;
  - ✓ Specific claims and payments received for services; and

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

Required documentation specific to this program:

The following must be documented in the client's medical record:

- Justification of the medical need for medical nutritionals;
- Justification for the method of administration when client is tube fed; and
- Copy of the medical care provider's prescription.

Additional information necessary for clients 20 years of age and younger:

- WIC denial for clients 5 years of age and younger; and
- A copy of the certified dietitian's initial evaluation, no more than 30 days after the initiation of medical nutritionals, and any follow-up evaluations done while the client is receiving medical nutritionals.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the Medical Assistance IDentification (MAID) card consisting of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare,

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: For clients 17 years of age and younger, enter the certified dietitian's name.

17a. **ID Number of Referring Physician**: For clients 17 years of age and younger, enter the MAA 7-digit certified dietitian provider number.

19. **Reserved for Local Use**: When applicable, enter one of the following indicators:

"**B" -** *Baby on Parent's PIC. (*Please specify twin A or B, triplet A, B, or C here)
"F" – Clients 4 years of age and younger when WIC is not being used.
"K" – Clients who have elected the hospice benefit, when billed charges are unrelated to the terminal diagnosis.
"L" – When the transition time from parenteral nutrition to medical nutritionals is greater than 3 months.
"**100 % nutrition - not included in NH**" **-** When billing for medical nutritionals for nursing home clients.

"**Not tube fed - Medicare does not cover.**"- When client has Medicare Part B.

If you have more than one EPA number to bill, place both numbers here.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing requires authorization, enter the 9-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 8, 2003 = 100803). ***Bill must not exceed a 1-month supply.***

24B. **Place of Service**: Required. Enter the following code:

Code	To Be Used For
12	Client's residence
22	Outpatient hospital
31	Nursing facility (formerly SNF)
32	Nursing facility (formerly ICF)

24C. **Type of Service**: Not Required.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: Must use the appropriate modifier when billing for medical nutritionals and supplies.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code that evidences the need for the use of medical nutritionals. A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (not to exceed a 1-month supply) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

GRP#: **Required.** Enter the 7-digit provider number assigned by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

WITH PRIOR AUTHORIZATION

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 032796 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM DD YY: 03 27 96 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR. JONES

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8888888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250.
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 354912345

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 03	10 01 03	12		B4034		250	1000	1				
2 10 01 03	10 30 00	12		B9998		250	27500	30				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 28500

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 28500

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY
13 ROSE STREET
UPTOWN, WA 98000 (206) 555-1111

PIN# 9045681 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

WITH EXPEDITED PRIOR AUTHORIZATION

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 032796 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM DD YY: 03 27 96 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR. JONES

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8888888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: LINE 1: 870000742/ LINE 2: 870000743

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250.__ 3. _____.__

2. _____.__ 4. _____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 354912345

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 03	10 01 03	12		B9998		250	15000	1				
2 10 01 03	10 30 00	12		B4150		250	27500	30				
3 10 01 03	10 01 03	12		E1399		250	10000	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 52500

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 52500

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY
13 ROSE STREET
UPTOWN, WA 98000 (206) 555-1111

PIN# 9045681 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A: <u>In Field:Please Enter:</u>

19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach MAA?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

> The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. **Insured's I.D. No.:** Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client. This information is obtained from the client's current Medical Assistance IDentification (MAID) card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.

17. **Name of Referring Physician or Other Source**: For clients 17 years of age and younger, enter the certified dietitian's name.

17a. **ID Number of Referring Physician**: For clients 17 years of age and younger, enter the MAA 7-digit certified dietitian provider number.

19. **Reserved For Local Use: Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission:** When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).**

24B. **Place of Service:** Required. Enter the following code:

Code	To Be Used For
12	Client's residence
22	Outpatient hospital
31	Nursing facility (formerly SNF)
32	Nursing facility (formerly ICF)

24C. **Type of Service:** Not Required.

24D. **Procedures, Services or Supplies HCPCS: Required. Coinsurance and Deductible:** Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code:** Required. Enter the ICD-9-CM diagnosis code that evidences the need for the use of medical nutritionals. A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges:** Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units:** Required. Enter appropriate number of units.

24K. **Reserved for Local Use:** Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment:** ***Required.*** Check **yes**.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Required. Put the *Name*, *Address*, and *Telephone Number* on all claim forms.

GRP#: **Required.** Enter the 7-digit provider number assigned by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

MEDICARE PART B CROSSOVER
(DO NOT FORGET TO ATTACH MEDICARE'S EOMB)

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 032732 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM DD YY: 03 27 32 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250.__ 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 03	10 30 03	12		B4034		250	1000	1				10.00
2 10 01 03	10 30 03	12		E0776	NU	250	10000	1				100.00
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. $ TOTAL CHARGE: 11000

29. $ AMOUNT PAID: 2000

30. $ BALANCE DUE: 9000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/01/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY
13 ROSE STREET
UPTOWN, WA 98000 (206) 555-1111

PIN# 9045681 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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Product Classification

Based on Centers for Medicare/Medicaid Services (CMS) guidelines, all enteral nutrition formulas are classified under one of six categories based on the composition and source of the ingredients in each product.

Category 1a (B4150)

Enteral formula consisting of semi-synthetic intact protein/protein isolates. Considered appropriate for the majority of clients requiring enteral nutrition:

Boost (with or without fiber)	Boost HP	Carnation Alsoy
Carnation Follow-up	Carnation Good Start	Enfacare
Enfamil	Ensure (with or without fiber)	Ensure High Protein
Fibersource	Glytrol	Isocal
Isomil	Isosource	Isosource HN
Jevity	Kindercal	Neosure
Nubasics (with or without fiber)	Nubasics VHP	Nutramigen
Nutren 1.0 (with or without fiber)	Nutren Junior	Osmolite
Pediasure	Portagen	Probalance
Promote (with or without fiber)	Resource	Resource Diabetic
Resource Just for Kids	Similac	Ultracal

Category 1b (B4151)

Blenderized enteral formula consisting of natural intact protein/protein isolates. Considered appropriate only for clients with a documented allergy or intolerance to semi-synthetic formulas:

Compleat
KetoCal
ProSobee

Category 2 (B4152)

Calorically dense intact protein/protein isolates. Considered appropriate only when determined medically necessary by a physician or nutritionist due to malabsorption conditions:

Boost Plus	Comply	Deliver 2.0	Ensure Plus
Ensure Plus HN	Isosource 1.5	Jevity 1.5 **Eff. 1/1/03**	Novasource 2.0
Novasource Pulmonary	Nubasics 2.0	Nubasics Plus	Nutren 1.5 & 2.0
Resource Plus	Respalor	TwoCal HN	VHC 2.25

Specialized Metabolic Nutrients

Category 3 (B4153)

Hydrolized protein/amino acids:

Alimentum	Criticare HN	Crucial
Cyclinex	Elecare	FAA (Free Amino Acid Diet)
GA 1 & 2	Glutarex 1 & 2	Glutasorb
Hominex 1 & 2	Impact Glutamine	Isotein HN
Ketonex 1 & 2	L-Emental	Neocate
Optimental	Pediatric Peptinex DT **Eff 1/1/03**	Peptamen 1.5
Peptamen Junior	Peptamen with Prebio 1	Peptinex DT
Phenex 1 & 2	Propimex 1 & 2	Reabilan
Subdue	Tyrex 2	Valex 1 & 2
Vital HN	Vivonex **Eff. 1/1/03**	Vivonex Pediatric

Category 4 (B4154)

Defined formula for special metabolic need:

Advera	AlitraQ	Amino-Aid
Calcilco XD	Choice DM	Diabetisource
Glucerna	HCY 1 & 2	Hepatic-Aid
Immun-Aid	Impact (with or without fiber)	Impact 1.5
Impact Recover	Isosource VHN	Lipisorb
L-Emental Hepatic	Lofenalac	LYS 1 & 2
Magnacal Renal	Modulen IBD	MSUD
Nepro	Novasource Renal	Nutrihep
Nutrirenal	Nutrivent	OS 1 & 2
Peptamen	Peptamen VHP	Perative
Phenyl-Free	Pregestimil	Product 3200AB
Product 3232	Pro-Peptide	Pulmocare
Re/Neph	RenalCal	Replete (with or without fiber)
Resource Benecalorie	Resource Diabetishield	SandoSource Peptide
Similac PM 60/40	Suplena	TraumaCal
Tyros 2	UCD 1 & 2	Vivonex Plus
Vivonex TEN		

Category 5 (B4155)

Modular components:

Additions
Immunocal
Peptinex **Eff. 1/1/03**
PhenylAde MTE
Product 80056
ProSure
Resource Arginaid
Upcal D
Casec
MCT Oil
PFD 2
Polycose Liquid & Powder
Promod
ProViMin
Resource Beneprotein
Duocal
Microlipids
PhenylAde
Pro-Cel
ProPhree
RCF
Resource Glutasolve

Category 6 (B4156)

Standardized nutrients:

Tolerex

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